

# LORD & CO. INSURANCE AGENTS

## Health Quote Information Request

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

- Insured: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_  
Tobacco:  Yes  No Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Health Conditions: \_\_\_\_\_
- Spouse: \_\_\_\_\_ Gender:  M  F Date of Birth: \_\_\_\_\_  
Tobacco:  Yes  No Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Health Conditions: \_\_\_\_\_
- Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender  M  F  
Health Conditions: \_\_\_\_\_
- Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender  M  F  
Health Conditions: \_\_\_\_\_
- Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender  M  F  
Health Conditions: \_\_\_\_\_

Current Health Coverage:  Yes  No

If "Yes," Name of Carrier: \_\_\_\_\_

How did you get our name? \_\_\_\_\_

Fax completed form to Margy Sundstrom at 940.387.6962.